TEXAS HIV MEDICATION PROGRAM
MEDICAL CERTIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN) **Texas HIV Medication Code (if known)**

The information requested is necessary to determine the patient's eligibility for program-supplied, HIV-related therapy as prescribed by you. All information requested will be kept strictly confidential by the Texas Department of State Health Services; personal identifying info is never released.

PATIENT INFORMATION

Full Name**:** _____

Mailing Address: _____ Apt #: _____

City, State, Zip: _____ Phone #: _____

Date of Birth: _____ Social Security Number: _____

*****NOTICE*** Changes in therapy after initial approval and/or recertification may be faxed to (512) 533-3178.**

I hereby certify that this patient has been diagnosed with HIV infection, and I am reporting the following viral load and CD4 count:

Plasma RNA Viral Load: **copies/ml**	**Test Date:**	**Current CD4 Count:**	**Test Date:**

PRESCRIBED MEDICATIONS FOR OPPORTUNISTIC INFECTIONS:

Please check here if patient is pregnant: ☐

- ☐ **acyclovir,** for acute or chronic herpetic infection *(**NOTE:** not all strengths available due to manufacturer shortages)*, **OR**
- ☐ **valacyclovir**, for acute or chronic herpetic infection
- ☐ **itraconazole**, for diagnosed histoplasmosis or blastomycosis (either caps or OS), **OR** for esophageal candidiasis (OS only)
- ☐ **clarithromycin**, for a current or previous mycobacterium avium complex (MAC) diagnosis, **OR**
- ☐ **azithromycin**, if client failed therapy on (or is intolerant of) clarithromycin
- ☐ **ethambutol**, for a current or previous mycobacterium avium complex (MAC) diagnosis
- ☐ **fluconazole**, for diagnosed cryptococcal meningitis or esophageal candidiasis
- ☐ **valganciclovir** (Valcyte), for diagnosed CMV disease with infection(s) of major organ(s) or organ system(s)
- ☐ **megesterol acetate**, for diagnosed cachexia or anorexia with profound, involuntary, acute weight loss ≥10% of baseline body weight or chronic weight loss ≥20% of baseline body weight
- ☐ **rifabutin** (Mycobutin), for a CD4 cell count ≤ 100
- ☐ **pyrimethamine** (Daraprim), for the treatment and suppression of toxoplasmosis
- ☐ **leucovorin** calcium tablets, used w/Daraprim for treatment/suppression of toxoplasmosis **(please provide RX dosage details)**
- ☐ **pentamidine** or ☐ **SMX/TMP** or ☐ **Dapsone** (choose one, if applicable), for CD4 ≤ 200, or thrush, or previous PCP diagnosis, or unexplained fever>100º for >2 weeks, **OR**
- ☐ **atovaquone** (Mepron), for diagnosed acute, mild to moderate PCP and intolerance to both SMZ-TMP and Dapsone

*****REQUIRED***** Is this patient naïve to antiretroviral therapy? (check one) ☐ Yes ☐ No

PRESCRIBED ANTIRETROVIRAL MEDICATIONS: MONTHLY CLIENT LIMIT OF FOUR ANTIRETROVIRALS (ARVs)

- ☐ **Atripla** (Sustiva/Truvada)*****
- ☐ **Combivir** (AZT/3TC)*****
- ☐ **Complera** (Edurant/Truvada)*****
- ☐ **Epzicom** (Ziagen/3TC)*****
- ☐ **Trizivir** (AZT/Ziagen/3TC)*****
- ☐ **Truvada** (Emtriva/Viread)*****
- ☐ **efavirenz** (Sustiva)
- ☐ **nevirapine** (Viramune XR)
- ☐ **raltegravir** (Isentress)
- ☐ **dolutegravir** (Tivicay)
- ☐ **rilpivirine** (Edurant)
- ☐ **tenofovir** (Viread)
- ☐ **etravirine** (Intelence) – For treatment experienced w/viral resistance/toxicity to ARV agents.
- ☐ **maraviroc** (Selzentry) – CCR5 monotropism proof via assay must be attached.
- ☐ **Stribild** (elvitegravir/cobicistat/Emtriva/Viread)*
- ☐ **atazanavir** (Reyataz)
- ☐ **darunavir** (Prezista)
- ☐ **indinavir** (Crixivan)
- ☐ **invirase** (Saquinavir)
- ☐ **lopinavir/ritonavir** (Kaletra)
- ☐ **nelfinavir** (Viracept)
- ☐ **ritonavir** (Norvir)
- ☐ **tipranavir** (Aptivus)
- ☐ **fosamprenavir** (Lexiva) – if unboosted dosage, written justification from physician required
- ☐ **cobicistat** (Tybost)
- ☐ **Prezcobix** (Prezista/Tybost)*
- ☐ **Evotaz** (Reyataz/Tybost)*
- ☐ **abacavir sulfate** (Ziagen)
- ☐ **didanosine** (DDI EC)
- ☐ **emtrictabine** (Emtriva)
- ☐ **lamivudine** (3TC)
- ☐ **stavudine** (D4T)
- ☐ **zidovudine** (AZT)
- ☐ **delavirdine** (Rescriptor)
- ☐ **enfuvirtide** (Fuzeon)
- ☐ **Triumeq** (Tivicay/abacavir/3TC)*
- ☐ **elvitegravir** (Vitekta)
- ☐ **Descovy** (Emtriva/Viread TAF)*
- ☐ **Odefsey** (Edurant/Emtriva/Viread TAF)*
- ☐ **Genvoya** (Vitekta/Tybost/Emtriva/Viread TAF)*

***Please note:** Combivir, Descovy, Evotaz, Epzicom, Prezcobix & Truvada each count as 2 ARVs; Atripla, Complera, Odefsey, Trizivir & Triumeq each count as 3 ARVs; Stribild and Genvoya each count as 4 ARVs.

PHYSICIAN SIGNATURE**:** _____ TX MD/DO LICENSE #: _____

PRINTED NAME OF PHYSICIAN: _____

OFFICE ADDRESS: _____

TELEPHONE: _____ FAX: _____ DATE: _____

THMP, ATTN: MSJA - MC1873, PO Box 149347, Austin, TX 78714-9347 **(5/2016)**